DOCUMENT RESUME

ED 379 554 CG 025 992

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TITLE Collective Definition of Practices Causing Dysfunction in Children.
PUB DATE [94]
NOTE 40p.
PUB TYPE Information Analyses (070)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Adolescents; Child Rearing; *Children; *Emotional Disturbances; Family Influence; Family Problems; Literature Reviews; *Parent Child Relationship; *Parent Influence; Predictor Variables
IDENTIFIERS *Dysfunctional Behavior; *Dysfunctional Family

ABSTRACT

The development of psychopathology stems, in large measure, from antecedent childhood stresses of maltreatment. This paper creates a list of factors that have been shown to lead to dysfunctional behavior. Such a list could be a valuable resource in the prevention and treatment of psychopathological behavior. A comprehensive cross-section of published literature on the topic was reviewed to determine the level of agreement of authorities on non-biological risk factors. The review showed that there is reasonable agreement on practices that tend to induce dysfunction. Sixteen of the more common hazards to children's development are presented here. Professional and public awareness of these chronic factors can be used to further the prevention of conditions known to place children at-risk for development of psychopathology. (Contains 103 references.) (Author/RJM)

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ED 379 554

Collective Definition of Practices Causing Dysfunction in Children

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Running head: Defining At-Risk Practices

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Abstract

The development of human psychopathology stems, in large measure, from antecedent childhood stresses of maltreatment. The purpose of this paper was to create a list of factors that have been shown to lead to dysfunctional behavior. Such a list could be a valuable resource in prevention and treatment. A comprehensive cross-section of published literature on the topic was reviewed to determine the level of agreement of authorities on non-biological risk factors. The review showed that, across all of the research reviewed, there is reasonable agreement on practices that tend to induce dysfunction. Professional and public awareness of these chronic factors can be used to further the prevention of conditions known to place children at-risk for development of psychopathology.

Collective Definition of Practices Causing Dysfunction in Children

A number of fields, including human development, psychiatry, psychology, counseling, and psychopathology, have dealt with the study of the mental disorders and psychiatric symptoms that constitute a quantitatively large and qualitatively serious array of health problems in our society (Allen & Gottfried, 1984; Bradshaw, 1990; Brody & Axelrod, 1978; Wheeler, 1988; Wolfe, 1988). Much of this work has focused on non-biological factors associated with mental disorder, in order to facilitate intervention and prevention (Haynes, 1992).

One common way that this knowledge base has been put into play is demonstrated by Satir's (1972) emphasis that, individuals must make complex choices on how tc provide the quality environmental conditions that will lead to healthier development. Satir recognized that these choices are complicated by the variety of models and suggestions on how such practices should be administered.

Research in child development has revealed the existence of certain variables that when present, tend to disrupt normal development (Allen & Gottfried, 1984). More specifically, the denial of basic needs, antecedent stresses of mistreatment and abuse, and extremes of parental behavior (Anna Freud, 1935; Lewis & Miller, 1990; Carl Rogers, 1939; "Mood Disorders", 1993) are cited as "toxic" factors that,

in conjunction with biological causes, supercede other environment enhancing forces and cause more children to grow into adulthood with dysfunctional behaviors.

Wolfe (1988) has stated that "...abuse and neglect are associated with a wide range of developmental deviations to such an extent as to warrant assessment and intervention services that curtail both the maltreatment and the concomitant environmental/family factors..." (p. 632). Data from this longitudinal study indicates childhood abuse/maltreatment is implicated in impaired development and later maladaptive behaviors.

The term dysfunction communicates the nature of the problem related to the development of psychologically unhealthy children and adults. In this paper, the term dysfunction was taken from the work of several authors, such as, Bradshaw (1990), Kessler & Goldstein (1986), and Whitfield (1987) and was defined as: chronic acting out (including psychiatric symptoms and mental disorders) in ways intended to control the environment, and that interfere with the ability of self and others to develop and thrive (including the accompanying discomforts and difficulties).

It remains to be determined if there is, throughout the literature, a unified and consistent set of practices, responsible for the development of dysfunction. Such a list would, as Haynes (1992) concluded, help guide professionals in the prevention of dysfunction, as well as, in their

intervention work with clients. A structured set of clear, concise guidelines that could be stated as behavioral objectives, and that have the authority of widespread "expert" agreement behind them, would appear to be a valuable resource for counseling professionals to share with consumers in learning to discontinue practices that cause eventual psychological harm to children.

The purpose of this paper will be: (a) to search the literature that addresses the risk factors relating to dysfunction, and (b) to compile from the literature a list of behaviors or events that have been shown to lead to dysfunction.

Review of the Literature

Psychoanalytic Theory

Brody and Axelrod (1978) pointed out that, while parenthood normally evokes love for children and a desire to nurture and protect, there happen to be no specific inherent behaviors in parents that make this so. In fact, they reported that the behaviors of parents can be elective or result from unconscious triggers, bringing the remnants of their own conflicts to their relationships with children, and resulting in emotional explosions that may be manifest as beatings and other aggressive acts. Brody and Axelrod cautioned that parents may also exagerate the importance of their children's needs as a result of their own emotional

struggles. In either event, they emphasized that the effect is to deprecate critical needs, resulting in a short curcuit of normal development.

Anna Freud (1935) concluded that there could be no development of emotional relations between parent and children when the environment included ill-treatment. She noted that an unfavorable environment would include violent swings between repression on the one hand, and total lack of restraint on the other. The typical dysfunction provoking environment, according to Freud, would have extremes of love and care, and total neglect. Freud was clear that the child does not need total admiration, nor do they need parental harshness where their fears are exploited and they are rendered impotent. Anna Freud believed in the power of the growing child and in the destructive force of the extremes in parental behaviors.

Sigmund Freud saw the symptoms of emotional illness as an "unresolved fixation to trauma" (cited in Frey-Rohn, 1974, p. 17). Jung refered to dysfunctions as "affect-toned disturbances" in which events were irrational and out of proportion (cited in Frey-Rohn, 1974, p. 18). According to Frey-Rohn, Jung felt that children's feelings associated with such an event would be too much to handle, would be repressed, and associations of the event would be carried and acted out unconsciously in other areas of life. Bettelheim, in his study of autism, felt that these children

had, early on, been subjected to behaviors of indifference, high anxiety, or retaliation that led them to believe that their existence was not desired (cited in Crain, 1992).

Through retrospective/prospective/longitudinal study (Putnam, 1993; Quinn, 1992; Terr, 1991), traumatic single episodes or chronic exposure to sexual abuse has been linked as a causal factor in eating disorders, self destructive tendencies, mood disorder, phobia, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), and aggression related disorders. Findings have suggested that the degree of psychopathology is related to the severity of abuse reported (Mullen, Martin, Anderson, Romans, & Herbison, 1993). Similarly, verbal abuse, physical abuse, and neglect of children have been shown to be associated with various subsequent psychiatric symptoms, such as hypochondriasis, conduct disorder, obsessive-compulsive disorder, aggression, sleep disturbance, depression, dissociation, and eating disorder (Barsky, Wool, Barnett, & Cleary, 1994; Gallagher, Flye, Hurt, & Stone, 1992; Goldner, Cockhill, Bakan, & Birmingham, 1991; Goodwin, 1988; "Mood Disorders", 1993; Pollock, Briere, Schneider, Knop, Mednick, & Goodwin, 1990; Pribor, Yutzy, Dean, & Wetzel, 1993; Rogeness, Amrung, & Macedo, 1986).

Chronically harsh and inconsistent parental discipline, in the form of physical punishment or shame inducing verbal punishment, appeared to be an important predictor of

psychiatric symptoms in adulthood (Frank, 1991; Hibbard, 1993; Holmes, & Robbins, 1984; Yorke, 1990). Wurmser (1981) focused on the use of shame as a parental control device and reported that the verbal communication of weakness, dirtiness, and defectiveness, as a regular method of exerting authority with children, is a form of trauma that later manifests as psychiatric disorder.

Learning Theory

B.F. Skinner, while focusing on the anatomy of conditioning, stated his views on the origin of dysfunction (cited in Sagal, 1981). Skinner advised against all forms of aversive control and manipulation of human beings, and stated that extremes of aversive treatment, such as neglect of needs and abusiveness, are the seeds of dysfunction (cited in Sagal, 1981). To both the behavioral and social learning theorists, the extremes of supression and repression produce intolerable side effects (Wheeler, 1988). The modelling of punishment or harshness simply causes repression and teaches children how to punish and be harsh (Wheeler, 1988). Deprivation of needs through neglect, supression, or punishment, is, in itself, dysfunctional and results in the sickness we see in society (Wheeler, 1988). Threatening events have been shown to produce patterns of arousal that severely tax human resources and result in reactions such as denial or neglect of self care (Taylor, 1991).

Developmental Psychology

Abraham Maslow identified six basic needs that are important to continued healthy development, arranged as a hierarchical model, where the fulfillment of the lower needs propels the organism on to the next higher level (cited in Crain, 1992). Maslow concluded that factors preventing children from fulfilling a basic need level will give them little opportunity to move to higher levels of need and development (cited in Crain, 1992).

Carl Rogers (1939) validated the need orientation of the developing child, and made a strong assertion that family situations that detract from these needs do bring about dysfunction in children. Parental behavior that models the rejection of reasonable needs, according to Rogers (1939), via parental rejection, cruel discipline, rejection of emotional contacts, suppression of healthy and empowering experiences, and compulsive efforts to control, are especially disintegrating social influences for developing children.

Gesell concluded that we should not try to force children into our own predetermined designs (cited in Crain, 1992). We should instead follow the child's cues that stem from their own "biological forces of growth" (cited in Crain, 1992). Subsequent studies have strongly suggested that emotionally ill adults were children whose natural impulses were given little attention and whose impulses were

felt to be extremely threatening to others, and that chronic or compulsive rejection of the child's natural tendencies is a danger to the child's functional development (cited in Crain, 1992).

Following in the work of Piaget, longitudinal research has focused on the effects that home environment has on the development of the cognitive domain (cited in Allen & Gottfried, 1984). This research has found specific factors negatively affecting the home environment, such as, inconsistency, crowding, overstimulation in physical and emotional areas, intense control efforts, and persistent unstructured stimulation (such as television).

Study of control versus autonomy during early adolescence has suggested control that is inappropriate to the level of autonomy needed is not healthy (Eccles, Buchanan, Flanagan, Fuligni, Midgely, & Yee, 1991). Research has tied the extremes of chaotic conflict versus non-conflict and control versus non-control with the developing symptoms of psychopathology (Worland, 1983). Abuse and neglect were generally associated with psychopathological consequences (Rosenthal, 1987), and traumatic events have been associated with chronic threat perception and stress response (Baum, O'Keefe, & Davidson, 1990).

Kinzl and Biebl (1992) have related incest, and other sexual abuse experiences in childhood, to later psychiatric

problems. Physical abuse was confirmed as a causal force in clinical levels of behavioral dysfunction in children and the presence of chronic verbal conflict and abuse was rated as a causal force in moderate behavior problems (Briere & Runtz, 1988; Fantuzo, DePeola, Lambert, Martino, Anderson, & Sutton, 1991; Kaufman & Cicchetti, 1989). Longitudinal study found that "hostile-harsh" parenting practices, as opposed to "firm-involved" practices, as reflected in parental affect and discipline, were predictive of internalizing and externalizing symptoms in children (Ge, 1993). Lack of parental support and parental isolation have been linked to child adjustment problems, and were found to be predictive of later psychopathology (Green, 1990).

The development of the Psychological Maltreatment Rating Scales recognized the more specific association of hostile behavior (verbal aggression and rejection) with self esteem problems and aggression issues, and psychological neglect (unavailability) with developmental disorders (Brassard, Hart, & Hardy, 1993). Specifically, the study defined spurning, rejection, degradation, terrorizing, age inappropriateness, emotional restriction, and isolation as forms of maltreatment that were predictive of subsequent dysfunction.

Other research that associated the development of dysfunction with antecedent maltreatment, defined maltreatment as a possible spectrum of behaviors (DePanfilis

& Salus, 1992; Wiehe, 1990). These were: (a) physical abuse which includes willful acts resulting in physical injury; (b) emotional abuse which includes rejection, scapegoating, prolonged confinement/isolation, belittling or shaming, prolonged chaos, unrealistic behavior demands, refusal to help as well as any comments aimed at ridiculing, insulting, threatening, or terrorizing; (c) sexual abuse defined as inappropriate sexual contact, including touching, penetration, or sexual exposure, and is present if the act is unwanted, done when developmentally inappropriate, or when perpetrated using manipulation or threat; and (d) neglect defined as refusal or delay in providing necessary care or exposing children to extreme situations, such as physical abuse or drug and alchohol abuse.

Ethology

John Bowlby (1973) established that children should experience a warm, intimate, and continuous relationship with their caregiver to insure mental health. Bowlby defined the absence of this as deprivation, which he found leads to anxiety, excessive drives, aggression, impulsivity, guilt, depression, as well as, nervous disorders.

Bowlby (1973) strongly stated a belief that management of dysfunction after it became rooted was an ineffective policy. Bowlby noted that prevention of the causal deprivation at the critical time in the development of the child was the appropriate remedy. He specifically found

isolation from the primary caregiver, inconsistency, emotional and physical isolation, physical and emotional cruelty, neglect of needs, chronic overcontrol, chronic lack of supervision, and repeated abandonment to be among the events causing deprivation and subsequent dysfunction.

Ainsworth (Ainsworth, 1962; cited in Bowlby, 1973; cited in Crain, 1992) concurred with Bowlby that deprivation, separation, and distortion of children's interactions with the caregiver produced insecure patterns of attachment and varying levels of psychopathology, depending on the nature of the interactions and the age of the children. Ainsworth observed that children who exhibited a defensive posture of avoidance were raised in an environment of insensitivity, interfering, and rejection, increasing the likelyhood that, as adults, they would be overly self reliant, hyper-vigilant, and unable to have close relationships. Those children who alternately displayed craving for parental attention and rejection of the parent, were found to have been exposed to inconsistent occurances of warmth versus rejection (cited in Bowlby, 1973; Crain, 1992).

Insecure patterns of attachment and subsequent psychopathology have been further noted in children subject to maltreatment (Cicchetti, 1987; Cicchetti, 1991) and subject to early need frustration (Lebovici, 1962). Other studies have found that conversely, overstimulation of a

child's environment, for example by parents wishing to guide their child's exposure to certain enrichment, tends to equally upset the child's natural drives through overt over control (cited in Crain, 1992).

Psychopathology

The results of studies in psychopathology strongly supported a predictive relationship between psychological, physical, and sexual maltreatment and subsequent dysfunction (Braver, Blumberry, Green, & Rawson, 1992; Hall, 1992; Harder, Cutler, & Rockart, 1992; Haynes, 1992; Miller, 1993; Moeller, Bachmann, & Moeller, 1993; Nash, Hulsey, Sexton, & Harralson, 1993; Putnam, 1993; Roesler & McKenzie, 1994; Sandberg & Lynn, 1992; Weaver, 1993). These studies found that resulting dysfunction included: serious anxiety, dissociative symptoms, mood disorder, psychotic symptoms, personality disorder, eating disorder, anti-social behavior, and psychosomatic symptoms.

Further retospective, prospective, longitudinal, and correlational studies have isolated the more specific elements of maltreatment which appear to precede subsequent dysfunction (Jacob, Leonard, & Krahn, 1987; Kessler & Goldstein, 1986; Lewis & Miller, 1990). Chronic family discord, characterized by chaotic conflict (Campbell, 1990; Chess & Thomas, 1984; Cicchetti & Olsen, 1990a; Herbert, 1991; Schuldberg, 1984), and the absence of positive attention and affective response (Schuldberg, 1984; Wolfe,

1988) were determined to place children at-risk for dysfunction. For children, the absence of mirrored empathy, intimacy, emotional availability, and acceptance of a full range of emotion is detrimental to the attachment process and problematic for future mental health (Campbell, 1990; Herbert, 1991; Martin, 1987; Osofsky, 1986; Perry & Perry, 1990). The absence of communication and the prevalence of isolation and non-responsiveness was further linked as a cause of dysfunction (Erickson, 1978; Hart & Brassard, 1991; Herbert, 1991; Lewis & Miller, 1990; Martin, 1987; McGee & Wolfe, 1991; Perry & Perry, 1990; Watt, 1986).

Environments that actively encourage repression and denial of feelings/needs were found to be determinant of future psychopathology (Lewis, 1990; Singer, 1990; Wolfe, 1988). Neglect was found to be problematic in the form of need-denial, bypassing reliable problem solving, and chronic exposure to unsafe situations (Chess & Thomas, 1984; Dohrenwend, 1986; Wahler & Dumas, 1987; Wolfe, 1988). The neglectful environment also can include exposure to undesirable practices, modelling of violence, and obsessive attachment to objects or behaviors (Frick, 1992; Hart & Brassard, 1991; Herbert, 1991; McGee & Wolfe, 1991). Lack of supervision, failure to have boundaries and limits, and denial of support were deemed critical factors placing children at-risk of developing psychopathology (Frick, 1992; Herbert, 1991; Perry & Perry, 1990; Watt, 1986).

A significant and common at-risk factor was found to be the use of coersion to force children to perform developmentally inappropriate demands for the gratification of others and at the expense of the childs basic needs (Chess & Thomas, 1984; Hart & Brassard, 1991; Wahler & Dumas, 1987; Watt, 1986). Terrorizing and threat (Hart & Brassard, 1991; Herbert, 1991; McGee & Wolfe, 1991), physical punishment and personal violation (Herbert, 1991; Singer, 1990; Wolfe, 1988), and shaming (Chess & Thomas, 1984; Harder, Cutler, & Rockart, 1992; Karen, 1992; Lewic, 1990; Tangney, Wagner, & Gramzow, 1992) were determined to be specific behaviors placing children at-risk of dysfunction. Chronic rejection, degradation, blaming, harsh judgement, scapegoating, and chronic criticism also were confirmed as factors causing dysfunction (Campbell, 1990; Hart & Brassard, 1991; Herbert, 1991; McGee & Wolfe, 1991; Perry & Perry, 1990; Watt, 1986; Wolfe, 1988).

Other research (Cullman, Epstein, and Lloyd, 1983; Herbert, 1991; Martin, 1987; Newton, 1988; Wahler & Dumas, 1987) identified ranges of behavior that swing wildly from restrictiveness to permissiveness, and swing between warmth and hostility. These studies found at-risk environments to be chronically inconsistent, ranging from indulging and sheltering to disregarding and domineering. The research identified a range in which adults model helplessness and withdrawal on the one hand and perfection and inflexibility

on the other, while using their experiences with children to satisfy their own needs and not the needs of developing children.

Counseling

Research in the field has positively linked categories of behavior (physical, emotional, and sexual abuse) with later development of psychopathology (Armsworth & Holaday, 1993; Jacob, Leonard, & Krahn, 1991; Jensen, Richters, Bloedau, & Davis, 1991; Reich, Earls, Frankel, & Shayka, 1993; Roosa, Beals, Sandler, & Pillow, 1990; Sher, Walitzer, Wood, & Brent, 1991). Armsworth and Holaday (1993) reported that at-risk factors stem from the acts and events that make up traumatic experiences.

Researchers have identified a profile of specific at-risk behaviors that includes the physical, emotional, and sexual abuse adults often perpetrate for their own benefit and use as weapons to control children (Beattie, 1987; Bradshaw, 1988, 1990; Hadley, Holloway, & Mallinckrodt; Hengeler & Bordwin, 1990; Satir, 1972; Thompson & Rudolph; Whitfield, 1987). They concluded that parents who are chronically inflexible, punishing, judgemental or evaluative, perfection obsessed, or critical will do harm to the child's development. According to this research, the dysfunctional parent used absence, ignoring (shunning), domination, and threat in their interactions with children. They also found failure to communicate, fighting over

control, blaming, chronic obsessive/compulsive activity, and using shame as a weapon to be at-risk behavior.

In addition, problem parental behaviors identified by those studying dysfunctional families include: inconsistency, regularly holding children responsible for the outcome of family life, distrust, constant chaos and crisis, regular rejection, taking choice away from children (helplessness/dependency), demanding that the child neglect their own feelings/needs, demanding a high level of tolerance of abuse/neglect from children, and expecting children to accept regular emotional and physical abandonment (Beattie, 1987; Bradshaw, 1988, 1990; Hadley, Holloway, & Mallinckrodt; Hengeler & Bordwin, 1990; Satir, 1972; Thompson & Rudolph; Whitfield, 1987). The studies concluded that these parental behaviors have the effect of cultivating obsessive/compulsive behaviors and stress disorders in children.

Conclusions

A review of all of the research examined confirmed that there is reasonable agreement on those practices that tend to cause dysfunction in the development of children. That is, there are parental behaviors that are contradictory to healthy child development and that undermine the best efforts of parents to enrich childhood experiences. Regardless of the theoretical orientation of the authors reviewed, there was literally unanimous agreement on the

kind of environment and behavior that increases the risk of unhealthy emotional development in children. In addition to the type of behavior, the research made statements regarding the prevalence of the behavior considered to be at-risk. While traumatic single episodes of some behaviors were agreed to be causal factor in mental disorders, it was agreed that chronic or habitual maltreatment best characterized problematic at-risk situations. The behaviors identified were stated with such conviction and with such unity across time and across schools of thought, as to be considered major working principles.

It is difficult to find ageement between theorists on how, exactly, the physical, cognitive, and psycho-social domains operate within the child and on how to best optimize the developmental process for children. It is easy, however, to identify, with experts' agreement, a finite list of priority hazards that are toxic to our children's development. Stated as behaviors to be avoided, the priority hazards found in the research can be summarized as follows (not in order of importance). Habitually:

1. making the child (beyond infancy) helpless and dependent on you and what you think.
2. restricting, interfering, or controlling.
3. ignoring a problem when you know there is one.
4. failing to supervise the child's activity.

5. engaging in emotional abuse, such as, harsh verbal punishment, threatening, aggression, judging, terrorizing, or any form of rejecting or putting down of the child's feelings or needs, in order to control.

6. reacting in a state of frantic anxiety to the child, living in chaos, engaging in emotional explosions, or communicating in an habitually critical or negative tone.

7. using physical punishment or pain as a way of control; in other words, physical abuse.

8. using a child as a target or object in any way that has to do with sex, having any activity you consider sexual with children, making jokes about their sexuality; in other words, sexual abuse.

9. acting untruthful to yourself or to the child, treating the child inconsistently, doing things that you insist the child not do.

10. shunning, avoiding physical contact, isolating the child, or not communicating with the child.

11. being absent from the child and not having the child with people they feel safely and warmly adjusted to.

12. avoiding taking care of something for the child considered important for children, neglecting a child, or depriving the child of basic needs (food, clothing, shelter, medical care, etc.) as a practice in parenting.

13. coercing the child to take care of what you want or need for your own pleasure and convenience, having

children perform in roles for which they are not developmentally prepared where it might not seem good for them, or where the child feels, or is, unsafe.

14. holding the child responsible for the way the family life is going or for the needs of the family.

15. shaming the child, "making the child feel bad", to get your way.

16. doing anything compulsive with or around the child.

While research tends to be in agreement that the parenting behaviors contained in these sixteen priority hazards place children at greater risk of dysfunction, it is vital that this determination be placed into its broader perspective as well as to remember that this is not a panacea. That is, when children are exposed to the aforementioned risk-factors, it is not absolutely certain that they will develop psychopathology. Exposure is a relative matter. Where maltreatment occurs in regular patterns, becomes the model of behavior, occurs compulsively, or represents the rule rather than the exception, it is considered to be especially toxic to healthy emotional development. The level of trauma or acuteness of the mistreatment also can influence the emotional impact that it has on children. Single or periodic occurrences of high risk behavior, such as especially invasive sexual, physical, or emotional abuse can

be very emotionally damaging to children. However, where maltreatment occurs as an occasional minimal event in an otherwise healthy environment, its impact might be negligible. Research confirms that supportive or mediating influences sometimes have a way of allowing children to develop in a healthy manner, despite the risk-factors (Moran & Eckenrode, 1992). The development of subsequent psychopathology would also depend on the genetic/biological factors present (Corwin, 1992).

Taken together, the contributors to the subject of parent-child communication seem to be saying that we have an important opportunity to help prevent or minimize trauma and emotional illness in our children. This is deemed possible if we can reduce the use of hazardous behaviors and promote more beneficial mediating behaviors while interacting with children.

There appears to be no unified, wide circulation of warnings that these practices are a major risk-factor in the development of dysfunction. We receive the clear message that smoking leads to cancer, so why not publish a list of practices in child rearing that childhood experts clearly believe leads to dysfunction? Why not, with the unity of a cross section of our nation's "experts", tell the world in clear, simple terms, that when you consistently use, for instance, harsh rejection in your parenting, you may be

contributing to dysfunction as surely as a cigarette may lead to cancer.

From a counseling standpoint, use of these risk-factors can be a resource in making clients aware of the sources of their own dysfunction, and can be vital in giving these clients a simpler model for improving their interactions with children and other adults. The ability of the counselor to emphasize the strength and conviction of the extensive research in this area can be a powerful tool for showing clients the consequences of "toxic" behaviors and for giving them a bit of a "yardstick" for deciding whether they need to ask for help staying clear of unhealthy practices. From the list of risk-factors, the counselor can custom-build models to fit the client and have a strong rationale for "selling" the necessity for change. Such a condensed list might be presented to caregivers in the following way: <u>For Parents and Caregivers</u>

Everyone wants to do what is best to help children grow up in healthy ways. It is also important to know that there are some things that are not healthy to do with children. In fact, after over 50 years of research, leading experts in psychiatry, psychology, child development, and counseling are in general agreement that some ways of treating children will significantly increase the risk of them developing various types of mental disorders. The following list can be a reminder of behaviors for parents to avoid when caring

for children: (a) controlling or manipulating; (b) failing to supervise or have boundaries; (c) putting-down or shaming; (d) threatening or terrorizing; (e) using a constantly critical or negative tone; (f) acting in frantic urgency, panic, or frustration; (g) inflicting physical pain; (h) involving children in sexual behaviors; (i) ignoring children's basic feelings, needs, and safety; and (j) holding children accountable for adult responsibilities.

If any of these on the list are used by a caregiver in working with children, it is vital that the caregiver get the help of a professional counselor to learn how to use more healthy ways to work with children and to learn how not to place the child in danger of harm.

From a parenting perspective, public awareness of these risk-factors can be encouraged by professionals and progress can be made in the prevention of dysfunction. We are fortunate that we can raise children without having to be perfect. There is a lot of room for mistakes and if things are generally "OK", then the child should grow functionally "OK". A fat reduced diet will still be successful even if the dieter "snitches" some ice cream, now and again, because over the long haul the fat intake would be vastly reduced. Parents can use their choice of child rearing methods, but so long as the toxic practices are vastly reduced, the chances of raising healthier children will increase.

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